I

103D CONGRESS
2D SESSION

H. R. 4960

To provide health care quality safeguards for consumers of health care insurance and health care products and services.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 12, 1994

Mr. WYDEN introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To provide health care quality safeguards for consumers of health care insurance and health care products and services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Consumer Health Quality Protection Act of 1994''.

TITLE I—DUTIES OF THE SECRETARY AND THE STATES

SEC. 101. RESPONSIBILITIES OF THE SECRETARY.

The responsibilities of the Secretary of Health and Human Services (hereinafter referred to as ''the Secretary'') under this Act are the following:

(1) STATE QUALITY MANAGEMENT PROGRAM.—Determination of initial and ongoing compliance of each State health quality management program with the requirements of section 102.

(2) NATIONAL QUALITY MANAGEMENT PROGRAM.—Establish a national quality management program (in accordance with section 201).

(3) HEALTH QUALITY IMPROVEMENT FOUNDATIONS.—Establishment of health quality improvement foundations (in accordance with section 202).

(4) CONSUMER HEALTH CARE ADVOCATE.—Establishment of consumer health care advocate in each State (in accordance with section 203).

(5) NATIONAL CONSUMER REPRESENTATIVE SUPPORT CENTER.—Establishment of a national consumer representative support center (in accordance with section 204).

(6) NATIONAL MEASURES OF QUALITY PERFORMANCE.—Establishment of national measures of

quality performance for health plans (in accordance with section 205).

(7) RELATIVE VALUE SCALE FOR PHARMACY COUNSELING.—Establishment of a relative value scale for the purpose of reimbursing pharmacists for the certain patient counseling services (in accordance with section 206).

SEC. 102. RESPONSIBILITIES OF THE STATES.

STATE RESPONSIBILITIES.—As a condition of receipt of Federal medical assistance payments under title XIX of the Social Security Act, a State must comply with the following requirements of this section:

(1) HEALTH PLANS.—Certifying health plan compliance with the quality standards of section 301.

(2) MEDICAL LICENSURE BOARD.—Assuring State medical licensure board compliance with the requirements of section 302.

TITLE II—NATIONAL HEALTH QUALITY MANAGEMENT PROGRAM

SEC. 201. ESTABLISHMENT OF NATIONAL QUALITY MANAGEMENT PROGRAM.

(a) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Secretary shall establish and oversee a performance-based program of quality man-

agement and improvement designed to enhance the quality, appropriateness, and effectiveness of health care items and services, to be known as the national quality management program.

(b) FUNDING.—

(1) IN GENERAL.—Beginning with the first quarter of the first calendar year following enactment of this Act and quarterly thereafter, the Secretary shall collect from each health plan certified under section 301 a fee amounting to 0.25 percent of the premiums received by the plan.

(2) FUNDED ACTIVITIES.—Funds collected under the authority of paragraph (1) shall be utilized by the Secretary solely to support the activities described under section 101.

SEC. 202. HEALTH QUALITY IMPROVEMENT FOUNDATIONS.

(a) IN GENERAL.—The Secretary shall, no later than two years after the date of enactment of this Act, establish a program of grants to eligible organizations to serve as health quality improvement foundations and perform the duties specified in subsection (d) for the population of each State, and shall oversee the operation of such foundations.

(b) ELIGIBILITY.—To be eligible for a grant under this section, entities must demonstrate compliance with the criteria of subparagraphs (1) through (5).

(1) GOVERNING BODY.—Each entity shall be governed by a board consisting of health professionals and public members, no fewer than 51 percent of whom shall be public members.

(2) DEFINITION OF PUBLIC MEMBER.—For purposes of this paragraph, the term ''public member'' means an individual who resides in the State and is a person of integrity and good reputation who has lived in the State for at least five years immediately preceding appointment to the board, and has not in the preceding five years been authorized to practice a healing art or had a substantial personal, business, professional, or pecuniary connection with a health plan, healing art or with a medical education or health care facility, except as a patient or a potential patient.

(3) STAFFING.—Each entity shall be staffed by individuals expert in quality improvement, and experts in the fields of epidemiology, measurement of risk adjusted health outcomes, use of clinical practice guidelines, health services data analysis, and provider education.

(4) CONTRACT WITH ACADEMIC HEALTH CENTER.—

(A) IN GENERAL.—Each entity shall have a contract with an academic health center to assist in fulfilling the duties described under subsection (d).

(B) DEFINITION.—For purposes of this paragraph, an ''academic health center'' means an entity that—

(i) operates a school of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education of the Association of American Medical Colleges and the American Medical Association, or the American Osteopathic Association;

(ii) operates or is affiliated with one or more schools of nursing; and

(iii) operates or is affiliated with one or more teaching hospitals.

(5) CONFLICT OF INTEREST.—

(A) IN GENERAL.—An entity seeking to receive a designation under this section shall be considered a ''disclosing entity'' for purposes of

section 1124 (42 U.S.C. 1320a–3) of the Social Security Act;

(B) Such entity may not—

(i) directly or indirectly (as determined by the regulations promulgated under section 1124(a)(3) of the Social Security Act) possess an ownership interest of one (1) percent or more in a health care facility, a health plan, or association of such;

(ii) own a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by a health care facility, health plan, association of such, or any of the property or assets thereof, which whole or part interest is equal to or exceeds (1) percent of the total property and assets of the facility, plan, or association; or

(iii) utilize officers or members of the governing body more than 10 percent of whom are the officers or members of the governing board of one or more health facilities, plans, or associations).

(c) GRANTS TO ENTITIES.—

(1) IN GENERAL.—The Secretary shall select, through a competitive grantmaking process, no more than one entity to serve as a health quality improvement foundation in each State, and may designate one entity to serve multiple contiguous States.

(2) PREFERENCES.—In making its designation, the Secretary shall give preference to an entity—

(A) which can demonstrate the capacity to fulfill the duties described under subsection (d) for enrollees of health plans certified under section 301, as well as enrollees of title XVIII of the Social Security Act; and

(B) for which the primary place of business is located in the State within which the functions of the foundation will be conducted, or, if one entity is to be designated to serve multiple States, preference shall be given to an entity for which the primary place of business is located in one of the States.

(3) SCOPE OF WORK.—Each grant with an entity under this section shall be pursuant to an agreement providing—

(A) the entity shall perform the duties described in subsection (d) for the benefit of—

(i) enrollees in health plans certified under section 301,

(ii) individuals enrolled under title XVIII of the Social Security Act, and

(iii) recipients entitled to benefits under title XIX of the Social Security Act.

(B) the Secretary shall evaluate the performance of the entity in carrying out the functions specified in the grant;

(C) the grant shall be for a term of four years and shall be renewable, based upon evidence of successful quality improvement performance, without reopening the competitive selection process, except that an entity subject to subsection (e)(3) shall have term(s) limited to two years and shall be subject to competition at the end of each contract period;

(D) if the Secretary decides not to renew a grant with a foundation, the foundation shall be notified of the decision at least one hundred and eighty days prior to the expiration of the grant term, and shall be afforded an opportunity to present information for the purposes of appeal of the decision not to renew the grant;

(E) based on a finding by the Secretary that the foundation has not met or no longer meets the requirements of this section, the Secretary may terminate the grant prior to its expiration upon one hundred and eighty days notice, during which notice period the Secretary shall provide the foundation an opportunity to seek an nonbinding opinion on the Secretary's finding before a panel of representatives of foundations convened by the Secretary;

(F) the entity may terminate the grant upon one hundred and eighty days notice to the Secretary; and

(G) the amount of the grant to be allocated under a grant shall consist of a sum necessary to perform the duties under paragraph (d), which may be augmented with additional funds for the performance of research by a foundation selected by the Secretary for exemplary performance and the merit of research proposals submitted.

(d) DUTIES.—A health quality improvement foundation shall carry out the following duties in the State in which the foundation operates:

(1) QUALITY IMPROVEMENT.—Collaboration with physicians and other health care professionals in ongoing efforts to improve the quality of health care provided to individuals in the State, giving priority to health conditions and interventions which are likely to produce the greatest impact in preventing or reducing morbidity, mortality, and functional impairment.

(2) OVERSIGHT.—Analyze data obtained under section 205 and other information obtained by the foundation pertaining to health care delivered in the State, for the purpose of—

(A) identifying opportunities for quality improvement;

(B) documenting that such improvement is being realized; and

(C) auditing samples of such information and its source documents to assure the information is valid, reliable, and comparable between plans, and to inform recommendations for improving the validity, reliability, and comparability of the information.

(3) TECHNICAL ASSISTANCE.—Provide technical assistance to health plans and providers, including—

(A) feedback to providers of information on patterns of health care delivery, health status, and outcomes;

(B) assistance in fulfilling the data reporting requirement of section 205;

(C) assistance in the development of patient education systems that enhance patient involvement in decisions relating to their health care;

(D) entering into agreements with selected health plans to provide educational programs for health care professionals.

(4) ANNUAL REPORT.—Submit to the Secretary and make publicly available an annual report concerning—

(A) recommendations for improving the utility of clinical practice guidelines as a means of identifying opportunities for improvement and bringing about quality improvement;

(B) recommendations for improving the reliability and validity of the national measures of quality performance and consumer survey data described in section 205;

(C) selected measures of the health care status of the population of the State, including

a description of activities underway and progress achieved; and

(D) a description of activities undertaken during the preceding year pursuant to subsection (b)(3) and subsection (d)(3)(D).

(5) MULTIPLAN COLLABORATIONS.—Sponsor of statewide and other collaborations involving multiple plans or providers to identify opportunities for quality improvement, and to bring about improvements in health care.

(6) REFERRALS.—

(A) IN GENERAL.—If a health quality improvement foundation finds, after affording reasonable opportunities for improvement, that a provider or plan—

(i) continues to furnish services characterized by underuse, overuse or poor technical quality, or

(ii) is unwilling or unable to successfully engage in quality improvement activities related to the services described in subparagraph (A),

the foundation shall provide notice of such finding to the officials and entities described in subparagraph (B), and shall make available to such officials and

entities upon request data and information relied upon by the foundation in making the referral.

(B) NOTIFICATION.—A finding under clause (i) shall be forwarded—

(i) if the finding pertains to a health plan, to the appropriate alliance(s), accreditation organization(s), State officials responsible for plan certification under section 301, the consumer health care advocate authorized under section 203, and the public;

(ii) if the finding pertains to a provider, to the appropriate State health facility or State professional licensure board(s), the consumer health care advocate authorized under section 203, and health plan(s) with which the provider is associated.

(iii) IMMINENT RISK.—If a foundation identifies a provider who posses an imminent risk to the health of patients receiving or likely to receive health care from the provider, the foundation shall immediately notify the appropriate authorities listed under clause (ii).

(e) LIMITATION ON LIABILITY.—No organization having a grant from the Secretary under this section, and no person who is employed by, or who has a fiduciary relationship with any such organization, or who furnishes professional services to such organization, shall be held by reason of the performance of any duty or activity authorized pursuant to this part to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided that the performance of such duty or activity was not conducted in bad faith.

SEC. 203 CONSUMER HEALTH CARE ADVOCATE.

(a) IN GENERAL.—The Secretary shall, no later than two years after the date of enactment of this Act, make grants to an entity in each State which shall serve as the consumer health care advocate for the population of the State.

(b) SELECTION OF GRANTEES.—

(1) COMPETITION.—Grants shall be awarded under subsection (a) on a competitive basis to applicants meeting the criteria in paragraph (2).

(2) CRITERIA.—In awarding grants under subsection (a)—

(A) preference shall be given to private organizations which are exempt from taxation

under section 501(c)(3) or (4) of the Internal Revenue Act of 1986;

(B) preference shall be given to organizations with a governing body which includes representation of ethnic and low-income populations of the State;

(C) preference shall be given to an organization which has previously received, and satisfactorily performed under the terms of a grant from the Secretary for the purpose of providing health insurance counseling for enrollees under title XVIII of the Social Security Act; and

(D) an applicant for a grant under subsection (a) shall be ineligible if the applicant is, or is affiliated with (through ownership, management, or common control), a health plan, provider, State office responsible for health facilities or health professional licensing or certification, health alliance, or association of such entities.

(c) GRANT PROVISIONS.—Each grant with an organization under this section shall provide that—

(1) the organization shall perform the duties set forth in subsection (d);

(2) the Secretary shall have access to documents and personnel necessary to evaluate the effectiveness of the organization in fulfilling the provisions of the grant;

(3) the grant shall be for an initial term of four years and shall be renewable thereafter based upon favorable performance without reopening the competitive selection process;

(4) if the Secretary intends not to renew a grant to an organization under this section, the organization shall be notified of the decision at least one hundred and eighty days prior to the expiration of the grant, and be afforded an opportunity to present information for the purpose of appeal;

(5) the Secretary may terminate a grant to an organization under this section if it determines that the organization does not meet the requirements of this section, and provides an opportunity for the organization to appeal its determination;

(6) an organization which has received a grant under this section may terminate the grant upon one hundred and eighty days notice to the Secretary;

(d) DUTIES.—An organization which has received a grant under this section shall have the following duties—

(1) investigate and resolve complaints made by or on behalf of individuals;

(2) provide information, referral and assistance to individuals on the availability of health insurance coverage and health care items and services;

(3) identify, investigate and promote solutions to problems arising from public or private practices and policies which adversely affect individuals' access to quality health care, including—

(A) marketing of health plans, and

(B) accessibility of services, subsidies or other resources;

(4) monitor, analyze, and comment on the development and implementation of Federal, State, or local laws affecting access to quality health care;

(5) facilitate public comment on Federal, State, or local laws affecting access to quality health care;

(6) compile and report to the Secretary and national consumer representative support center data regarding complaints received and actions taken, in a form defined by the Secretary;

(7) protect the identity of any complainant, unless released from this responsibility by the complainant;

(8) coordinate activities and advocacy with other organizations, including legal assistance providers, State and local long-term care ombudsman programs, and protection and advocacy programs established for persons with disabilities under—

(A) part A of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001 et seq.),

(B) the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10801 et seq.), and

(C) the Americans with Disabilities Act;

(9) perform such other duties the Secretary may specify.

(e) AUTHORITY OF CONSUMER HEALTH CARE ADVOCATE.—The consumer health care advocate in each State shall be vested with the following powers and authorities:

(1) The advocate may establish local programs with the same powers and authorities, subject to the same restrictions regarding eligibility and conflict of interest.

(2) Representatives of the consumer health care advocate shall have access to health care facilities for the purpose of communicating with individuals receiving care on the premises.

(3) Representatives of the consumer health care advocate shall have access to the medical and social records of an individual if the individual, or the legal representative of the individual, has granted permission to do so.

(4) The consumer health care advocate shall have access to, and upon request copies of, all licensing and certification reports and data pertaining to health care providers and developed by a State.

(f) LIMITED LIABILITY.—No consumer health care advocate or its local programs or representatives shall be liable under State or Federal law for the good faith performance of official duties.

(g) FUNDING.—The Secretary shall provide funding for the entities described under this section through the following mechanisms:

(1) BASE FUNDING.—The Secretary shall provide grants to the consumer health care advocate in each State and the Center described under subsection (g) from the proceeds of the assessment under section 201, up to a total of $50,000,000; and

(2) VOLUNTARY CONTRIBUTIONS.—The Secretary shall assist States in ensuring that consumer health care advocate entities are permitted to seek voluntary contributions through a prominent solicita-

tion in the enrollment materials distributed by or on behalf of each health plan.

SEC. 204 NATIONAL CONSUMER REPRESENTATIVE SUPPORT CENTER

The Secretary shall, no later than six months after the date of enactment of this Act, make one or more grants of a total amount not exceeding $5,000,000 per annum to establish national consumer representative support center(s) to assist consumer representatives serving on State medical boards, quality improvement foundation governing boards, and consumer health care advocates in performing their duties. Entities eligible for a grant under this section shall be nonprofit organizations with demonstrated expertise in training and representing diverse consumers of health care insurance, and health care items and services.

SEC. 205. NATIONAL MEASURES OF QUALITY PERFORMANCE.

(a) IN GENERAL.—The Secretary shall develop a set of national measures of quality performance, which shall be used to assess the provision if health care services and access to such services.

(b) SUBJECT OF MEASURES.—National measures of quality performance shall be selected in a manner that provides information on the following subjects:

(1) Access to health care services by consumers;

(2) Appropriateness of health care services provided to consumers;

(3) Outcomes of health care services and procedures;

(4) Health promotion;

(5) Prevention of diseases, disorders, and other health conditions;

(6) Consumer satisfaction with care, including satisfaction of consumers who disenroll from health plans and those who utilize services from providers not included in their plan network.

(c) SELECTION OF MEASURES.—

(1) CONSULTATION.—In developing and selecting the national measures of quality performance, the Secretary shall consult with appropriate interested parties, including—

(A) States;

(B) health plans;

(C) employers and individuals purchasing health care through regional and corporate alliances;

(D) health care providers;

(E) health care consumers;

(F) the quality improvement foundations established under section 202;

(G) the consumer health care advocate established under section 203;

(H) nationally recognized accreditation organizations.

(2) CRITERIA.—The following criteria shall be used in developing and selecting national measures of quality performance:

(A) SIGNIFICANCE.—When a measure relates to a specific disease, disorder, or other health condition, the disease, disorder, or condition shall be of significance in terms of prevalence, morbidity, mortality, or the costs associated with the prevention, diagnosis, treatment, or clinical management of the disease, disorder, or condition.

(B) RANGE OF SERVICES.—The set of measures, taken as a whole, shall be representative of the range of items and services provided to consumers of health care by health care providers and suppliers.

(C) RELIABILITY AND VALIDITY.—The measures shall be reliable and valid.

(D) UNDUE BURDEN.—The data needed to calculate the measures shall be obtained without undue burden on the entity or individual providing the data.

(E) LINKAGE TO HEALTH OUTCOME.—When a measure is a rate of a process of care, the process shall, to the extent practicable, be linked to a health outcome based upon the best available scientific evidence.

(F) CONTROL AND RISK ADJUSTMENT.—When a measure of a provider or plan is an outcome of the provision of care, the outcome shall be within the control of the provider or plan and shall be one with respect to which an adequate risk adjustment can be made.

(G) PUBLIC HEALTH.—The measures shall incorporate standards identified by the Secretary of Health and Human Services for meeting public health objectives.

(d) UPDATING.—The Secretary shall review and update the set of national measures of quality performance annually to reflect changing goals for quality improvement. The Secretary shall establish and maintain a priority list of performance measures that within a five-year period it intends to consider for inclusion within the set

through the updating process. The Secretary may select different performance measures for inclusion within the set from year to year.

(e) CONSUMER SURVEYS.—

(1) IN GENERAL.—The Secretary shall conduct periodic surveys of health care consumers to gather information concerning access to care, use of health services, health outcomes, and patient satisfaction. The surveys shall monitor consumer reaction to the implementation of this Act and be designed to assess the impact of this Act on the general population of the United States and potentially vulnerable populations.

(2) SURVEY ADMINISTRATION.—The Secretary shall develop and approve a standard design for the surveys, which shall be administered by the Administrator for Health Care Policy and Research on a plan-by-plan and State-by-State basis. A State may add survey questions on quality measures of local interest to surveys conducted in the State.

(3) SAMPLING STRATEGIES.—The Secretary shall develop sampling strategies that ensure survey samples adequately measure populations considered by the Secretary to be at risk of receiving inadequate health care or who may be difficult to reach

through consumer sampling methods, including individuals who—

(A) fail to enroll in a health plan;

(B) resign from a plan;

(C) are members of a vulnerable population, as defined by the Secretary; or

(D) have received health care items or services from providers or suppliers which were not members of the network maintained by the plan in which the individual was enrolled.

(f) EFFECTIVE DATE.—The requirements of this section taken effect upon the date of enactment of this Act, with the first publication for comment of draft performance measures defined under subsection (a), and the surveys described under subsection (e), to take place no later than two years after the date of enactment of this Act. The Secretary shall publish, for use by the public in evaluating health plans and providers, the first set of performance measures no later than three years after the date of enactment of this Act.

SEC. 206 PAYMENT FOR PHARMACIST COUNSELING.

(a) RELATIVE VALUE SCALE FOR EVALUATION AND MANAGEMENT SERVICES BY PHARMACISTS.—The Secretary shall develop and publish, no later than three years from the date of enactment of this Act, a relative value

scale that defines and establishes a numerical relationship among various evaluation and management services performed by pharmacists, taking into account—

(1) differences in skill levels and training required to perform the services;

(2) differences in level of risk associated with use of individual drugs or groups of drugs; and

(3) differences in the level of risk associated with drug use by certain individuals.

(b) REPORT TO CONGRESS.—No later than three years after the date of enactment of this subsection, the Secretary shall provide to Congress a report on the relative value scale developed under paragraph (1), together with recommendations regarding adoption of such scale by Federal health insurance programs and by health plans certified under section 301.

TITLE III—STATE HEALTH QUALITY MANAGEMENT PROGRAMS

SEC. 301 CERTIFICATION OF HEALTH PLANS.

(a) IN GENERAL.—(1) To be certified by a State, a plan must be determined to be in substantial compliance with the standards described in this section.

(2) OVERSIGHT.—The Secretary may conduct onsite inspections and inspect documents generated by or in the possession of a plan, accreditation organization, or State,

to verify the compliance of a plan with the requirements of this section.

(b) ACCREDITATION.—A State may accept, in lieu of making its own determination of compliance with these standards, the determination of compliance by an accreditation organization designated by the Secretary as utilizing a process consistent with subsection (c).

(c) PROCESS.—A State or accreditation organization making a determination under subsection (a)—

(1) shall verify compliance with each of the standards under this section.

(2) shall make available to the public its findings related to a plan's compliance with each of the standards under this section.

(3) may charge plans fees sufficient to cover the cost of assuring compliance with the standards under this section.

(d) QUALITY STANDARDS.—

(1) QUALITY IMPROVEMENT.—

(A) IN GENERAL.—Each health plan shall establish a quality improvement program to systematically measure, assess and improve enrollee health status, patient outcomes, processes of care, and enrollee satisfaction associated with health care provided under the plan.

(B) FUNCTIONS.—Each quality improvement program shall perform the following functions—

(i) measure performance of the plan and its member providers, using at least the quality measures developed under section 5003, and communicate findings of such monitoring to such providers and plan administrative personnel;

(ii) furnish the information required under subtitle B of this title and provide such other reports and information on the quality of care delivered by providers as may be required under this Act;

(iii) demonstrate measureable improvement in medical outcomes (including morbidity, mortality, functional impairment, and quality of life), as measured by the plan and as assessed by plan enrollees and patients;

(iv) establish procedures for—

(I) educational intervention when services characterized by underuse, overuse, or poor technical quality are provided, and

(II) referral to State licensure board or other appropriate regulatory authorities if the interventions described in subclause (I) are unsuccessful; and

(v) cooperate with the health quality improvement foundation established under section 5008, including providing access to appropriate medical records and quality performance data upon the request of such foundation, and undertaking investigation of quality problems and opportunities for quality improvement identified by the foundation.

(2) COMMUNITY HEALTH IMPROVEMENT.—

(A) IN GENERAL.—Each health plan shall establish a community health improvement program that meets the requirements of subparagraph (C) for the benefit of—

(i) plan enrollees; and

(ii) uninsured individuals residing in the geographic area served by the plan, or, with respect to self-insured plans, the geographic area served by insured plans in

which the plan's principle place of business is located.

(B) REQUIREMENTS.—A community health improvement program shall consist of:

(i) identification of baseline health status problems in the population addressed by the program;

(ii) development of measures to address such problems in consultation with local public health officials, community organizations, and other health plans operating in the service area of the plan;

(iii) implementation of measures developed under clause (ii);

(iv) evaluation of the effectiveness of such measures in improvement of health status in the population; and

(v) an annual report of the results of the evaluation.

(3) UTILIZATION MANAGEMENT.—

(A) IN GENERAL.—The utilization management activities of a plan are subject to the requirements of this paragraph to the extent such activities involve case by case review of care proposed for or provided to individual pa-

tients. A plan may satisfy the requirements of subparagraphs (C) through (G) by conducting its utilization management efforts through its quality improvement program.

(B) Disclosure of utilization management criteria upon the request of practitioners or enrollees.

(C) Inclusion of utilization management criteria to identify underutilization as well as overutilization.

(D) Systematic updating of utilization review criteria to reflect current scientific and medical findings.

(E) Supervision of utilization determinations by qualified medical professionals.

(F) Consistency in the application of utilization review criteria.

(G) Personnel responsible for utilization management shall—

(i) monitor the outcome of utilization management decisions which are appealed by an enrollee or provider, and

(ii) revise utilization management criteria and procedures to eliminate future reversed decisions to the extent practicable,

except where such reversals were not the result of deficiencies in such criteria or procedures.

(4) PHYSICIAN INCENTIVE PLANS.—

(A) IN GENERAL.—A health plan may establish and operate a physician incentive plan (as defined in subparagraph (B)) if—

(i) the requirements specified in clauses (i) through (iii) of section 1876(i)(8)(A) of the Social Security Act are met (in the same manner as they apply to eligible organizations under section 1876 of such Act); and

(ii) the plan prominently discloses to the public, in its enrollment information, the nature of the incentives provided to providers under the plan.

(B) DEFINITION.—For purposes of this paragraph, the term ''physician incentive plan'' means any compensation or other financial arrangement between a health plan and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled under the plan.

(5) ENROLLEE RIGHTS AND RESPONSIBILITIES.—

(A) IN GENERAL.—A plan shall provide to all enrollees written information, translated for the benefit of any population representing 5 percent or more of the plan's enrollees whose primary language is other than English, describing—

(i) enrollee rights and responsibilities, including the grievance and appeals rights defined in subpart C of this title, the rights defined in subparagraphs (B) through (H), and

(ii) any limitations of coverage, exclusions, and out-of-pocket costs (including any copayment, coinsurance, deductible) and any limit(s) on out-of-pocket costs.

(B) WAIVER OF RIGHTS.—No health plan or provider may require an individual or enrollee to waive the rights set forth in this paragraph as a condition of enrollment in a plan, admission to a health care facility, or provision of treatment.

(C) RIGHT TO REFUSE TREATMENT.—Each enrollee shall have the right—

(i) to refuse any health care item or service;

(ii) to refuse to receive any health care item or service from a specified provider;

(iii) to leave the premises of any provider, except as otherwise provided under law;

(iv) to refuse participation in experimental research, and to have either a refusal or consent documented in the medical record, except the (HHS) Secretary may define in regulations circumstances under which obtaining consent directly from a patient is not possible; and

(v) to receive an explanation of any available alternative item, service, or provider, and any likely medical consequences of the exercise of the rights described in clauses (i)–(iv).

(D) RIGHT TO PARTICIPATE IN PLANNING TREATMENT.—Enrollees shall have the right to participate in the planning of their health care, including the opportunity to discuss treatment alternatives with providers and to be rep-

resented in such discussions by a family member or other chosen representative.

(E) RIGHT TO CHOOSE PRIMARY CARE PHYSICIAN.—Each plan shall permit enrollees to choose a primary care physician from among providers who are members of the plan, and permit enrollees to change physicians upon request.

(F) RIGHT TO PRIVACY.—Enrollees shall have the right—

(i) to privacy in regard to their health care during discussion or consultation among providers regarding their care, physical examination, and treatment; and

(ii) while admitted to a health facility, to associate and communicate privately with persons of their choice, including being afforded opportunities to communicate privately with a representative of the consumer ombudsman or protection and advocacy organization, upon the request of such representative.

(G) RIGHT TO MEDICAL RECORDS.—Enrollees shall have a right to review and, for a

nominal charge, copy, their own medical records during business hours.

(H) RIGHT TO CONFIDENTIALITY OF RECORDS.—Enrollees shall be assured confidential treatment of their medical records, and shall be afforded the opportunity to approve or refuse their release to any individual other than providers involved in their care, except the Secretary, entities authorized under section 5008 of this Act, or others granted access to such records by law.

(6) PRACTITIONER CREDENTIALING AND COMPETENCY.—Each health plan shall—

(A) establish an ongoing credentialing and recredentialing process for all physicians and other licensed practitioners which are members of the plan;

(B) require practitioners applying for membership to complete an application and statement attesting to their professional standing and the accuracy of all information provided;

(C) assure the demonstrated competence of member practitioners to perform the duties under the plan's membership agreement, and

establish policies and procedures for educational intervention or reduction, suspension, or termination of privileges of practitioners failing to demonstrate competence.

(7) INFORMATION MANAGEMENT.—Each health plan shall—

(A) protect the confidentiality and security of information identifying any individual enrollee;

(B) standardize throughout the health plan and its member providers, to the extent practicable and consistent with the requirements of section 205, data sets, codes, definitions, classifications, and terminology.

(8) DISCLOSURES RELATED TO MARKETING INFORMATION.—

(A) Each health plan which sponsors or distributes any comparative information pertaining to plans marketed in an area shall prominently disclose in such information—

(i) the identity of the plan (or related organization) sponsoring or distributing the comparative information, and whether the performance of the plan (or organization) is included in the comparative infor-

mation being sponsored or distributed by such plan; and

(ii) if clinical outcomes or other clinical performance data are included in such information, whether such data were adjusted to reflect the health status and severity of illness of enrollees or patients included in such comparisons, and the method by which any severity adjustment was accomplished.

(B) Enrollment materials provided to potential enrollees by each health plan shall make a prominent disclosure of the features, availability, cost sharing and the additional premium cost (if any) associated with purchase of the self-referral option described in paragraph (11).

(9) COUNSELING REQUIREMENTS FOR PHARMACIES.—Each health plan shall ensure that no pharmacy may receive payment from the plan for dispensing a covered outpatient drug unless the pharmacy agrees that a pharmacist employed by the pharmacy will ask individuals enrolled in the plan who receive a covered outpatient drug from the pharmacy questions regarding—

(A) the appropriate use of the drug,

(B) major potential interactions between the drug and other drugs used by the individual, and

(C) other questions necessary to determine, in the professional judgment of the pharmacist—

(i) whether the individual understands and is likely to comply with instructions for the safe and effective use of such drugs, and

(ii) if any counseling or other action by the pharmacist is needed.

(10) VOLUNTARY CONTRIBUTIONS.—Each health plan shall, upon the request of the consumer health care advocate described under section 203—

(A) publish in a prominent location in its enrollment document a solicitation for voluntary contributions for the consumer health care advocate designated by the Secretary to serve the State; and

(B) collect such contributions, through the same mechanism as periodic premium payments of the enrollee are collected, and forward them to the consumer health care advocate no less frequently than monthly.

(11) POINT OF SERVICE OPTION.—

(A) IN GENERAL.—Each health plan which utilizes a network of providers or suppliers shall offer potential enrollees a point of service option, permitting such enrollees to receive all covered items and services from suppliers and providers that are not members of the plan's network, subject to the conditions described in paragraphs (B) through (D).

(B) COST SHARING.—For items and services received from out-of-network providers or suppliers, enrollees who have purchased the point of service option shall be subject to—

(i) a deductible not to exceed $200,

(ii) coinsurance at a rate no greater than 150 percent of the coinsurance rate established for items and services purchased through the plan's network,

except that for individuals with incomes below 150 percent of the applicable poverty level, the Secretary shall establish a deductible and coinsurance level which is higher than the amounts paid by such individuals for items and services received from network providers and suppliers,

but which will not pose an unreasonable barrier to exercise of the point of service option.

(C) SELF-REFERRAL.—With respect to an enrollee who has purchased the point of service option, no plan may require a referral from a network provider as a precondition of coverage of out-of-network items and services.

(D) MEDICAL NECESSITY.—A plan may deny payment for items or services received from an out-of-network provider or supplier if such items or services were not medically necessary.

SEC. 302. STANDARDS FOR STATE MEDICAL BOARDS.

(a) REQUIREMENTS FOR STATE BOARD OF MEDICAL EXAMINERS.—

(1) PUBLIC ACCOUNTABILITY.—Each State Board of Medical Examiners shall make available to the public upon request:

(A) a description of any final actions (including those described in paragraph (4)(E)) taken by the Board with respect to a physician;

(B) an annual performance report indicating the number and type of investigations undertaken and actions taken by the Board during the preceding year.

(2) COMPOSITION OF BOARD OF MEDICAL EXAMINERS AND COMMITTEES.—Each State Board shall be structured so as to include:

(A) public members in sufficient numbers that no fewer than fifty percent of board members are public members;

(B) in the membership of each committee or subdivision of the board, at least one public member.

(3) FUNDING.—

(A) Each State medical licensure board shall be adequately funded to fulfill the requirements of this section.

(B) All revenue generated by medical licensure fees shall be used to fund the activities of the State medical board, to the extent necessary to fulfill the requirement of subparagraph (A).

(4) INVESTIGATIONS.—A State medical licensure board shall—

(A) investigate any credible evidence which alleges that a physician—

(i) is incompetent to perform the duties reflected in the physician's license;

(ii) engages in unprofessional conduct that jeopardized patients;

(iii) is mentally or physically unable to safely and effectively perform the duties reflected in the physician's license;

(B) employ or arrange for the availability of personnel with the appropriate medical training necessary to investigate and document findings related to allegations described in subparagraph (A);

(C) investigate allegations submitted to the board by a health quality improvement foundation established under section 202.

(D) possess the following investigative powers:

(i) the power to subpoena documents and individuals possessing information relevant to investigations;

(ii) the power to require professional competency examinations upon reasonable suspicion of incompetence;

(iii) the power to obtain the involuntary temporary summary suspension of a licensee from practice, based upon a reasonable belief that the licensee poses an imminent threat to patient health, followed as soon as practicable by a formal hearing;

(E) possess the following authorities related to disciplinary action:

(i) revocation or suspension of a license;

(ii) restriction or limitation of the extent, scope, or type of practice, including the authority to order such limited practice to be conducted under the supervision of another licensee;

(iii) imposition of civil penalties;

(iv) issuance of a warning or reprimand;

(v) probation with or without conditions, such as submission to treatment, continuing education, or reexamination;

(vi) the authority to condition a reinstatement of a license or removal of license limitations upon the licensee obtaining minimum results on one or more forms of competency examination, and

(vii) assessment of the reasonable costs of investigation, hearings or reviews, and supervision of practice.

(b) ELIGIBILITY FOR GRANTS.—

(1) IN GENERAL.—The Secretary may make a grant to a State Board of Medical Examiners for any purpose related to its duties under this section, or for demonstration projects, if such Board demonstrates it is eligible under paragraph (2).

(2) ELIGIBILITY.—A State Board of Medical Examiners is eligible for a grant under paragraph (1) if the Secretary determines that the Board is in substantial compliance with this section and the current model standards established by the Federation of State Medical Boards.

(3) CONSTRUCTION.—If any of the model standards referred to in paragraph (2) are inconsistent with the provisions of this section, the Secretary's determination of eligibility shall be based upon on compliance with the requirements of this section.

(c) DEFINITIONS.—

(1) For purposes of this section, a ''Board of Medical Examiners'' shall have the meaning given in section 431(14) of the Health Care Quality Improvement Act of 1986.

(2) For purposes of this section, a ''public member'' means an individual who resides in the State and is a person of integrity and good reputa-

tion who has lived in the State for at least five years immediately preceding appointment to the Board, and has never been authorized to practice a healing art, and has never had a substantial personal, business, professional, or pecuniary connection with a healing art or with a medical education or health care facility, except as a patient or a potential patient.

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